

Compliance Plan



Victor Treatment Centers
Victor Community Support Services
North Valley Schools
2561 California Park Drive
Chico, CA

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Section 1: Introduction

Victor is a private non-profit organization with a partnership of two organizations dedicated to serving the most troubled children throughout California. These organizations . Victor Treatment Centers and Victor Community Support Services . have operated for over forty years to provide innovative services to children and families across the state. Victor is dedicated to learning, exploring new approaches, building new services, and maintaining its commitment to treating children in the most professional, least restrictive, community-based settings possible.

Mission and Core Values

***Our mission is to be a catalyst for sustained improvement
in the lives of those we touch.***

Each and every action we take is evaluated against our mission. The culture we seek to create at each program ensures that we achieve our mission. At Victor, we adhere to a set of core values that direct our decision-making, policies, and standards of conduct:

- Teamwork
- Excellence
- Adaptability
- Mission Driven

Victor's Compliance Program

Victor has clearly defined job expectations, including the manner in which services will be delivered. For many years various methods of oversight have been employed to monitor compliance issues. Some of these include: close supervision, peer audits, quality documentation workgroups, regular agency chart reviews, and participation with County led documentation reviews.

As part of its commitment to excellence, Victor has developed a Compliance Program to ensure that all programs and employees adhere to all federal, state, and county regulations governing MediCal service delivery. The Compliance Program is coordinated by the Agency Compliance Officer, who works in tandem with representatives from each program to comprise the Agency Compliance/CQI Workgroup. The Compliance/CQI workgroup has as its role the development and monitoring of compliance procedures throughout Victor programs.

1. Written Policies and Procedures

a. Standards of Conduct

Victor is dedicated to quality services and compliance throughout the Agency. Our compliance record is exemplary with excellent audits and a near zero error rate in our many years of service. Victor has achieved this through responsible hiring, superior training, and careful attention to federal, state, and county regulations. We work closely with our partners in the community and maintain open channels of communication.

Each employee at time of hire is referred to the Personnel Policies and an Employee Handbook for which they sign that they have received and read. Subsequent annual revisions of these policy documents require a further signed acknowledgement. In addition employees sign a Code of Conduct agreement (*see Attachment E, page 33*) that defines expected behavior regarding the adherence to statutes, regulations and guidelines applicable to Federal Health Care Programs and compliance issues in general. The handbook is also available on-line for ready access at our website at victor.org.

Separately there are clearly written, definitive Policies & Procedures in hard copy and on-line for all staff to access through the Victor Employee Information Resource Center (EIRC). These directories explain in detail the Agency's regulations regarding office administration, service provision and documentation requirements to mention a few topics. Again, on-line and available to staff, are training manuals of quality documentation standards and detailed explanations for service procedures. In addition, there is a highly developed Mental Health Service Client Database with the ability to track service delivery.

b. Written Compliance Policies and Procedures

The Federal False Claims Act was enacted during the Civil War to combat fraud against the federal government by suppliers for the war effort. In 1986 it was amended to combat the abuses in the defense contracting industry. Today the False Claims Act primarily has

become the federal government's most effective and successful tool in combating waste, fraud and abuse in federal spending.

The Federal False Claims Act is composed of civil and criminal components. Under the civil portion the federal government does not have to prove intent but only that there exist claims that are not valid. The criminal component requires that willful misrepresentation be shown to exist in the submission of claims. The California State False Claims Act is similar in intent to the Federal False Claims Act.

There is federal and state Whistleblower protection to guard against any retaliation against those who disclose non-compliance information to a government or law enforcement entity. Employers are prevented from discriminating in any way against such whistleblowers. Individuals who initiate compliance lawsuits can be awarded from 15% to 33% of the money recovered in the action.

The provision of mental health care services to segments of the population has become a large investment of the federal government. To monitor and protect that investment, Victor compliance programs/compliance members have become vital to the process of service delivery. The duties and responsibilities of the Compliance Officer include: maintaining/overseeing compliance activities; communication with and training of staff as needed; and acting as a liaison within the Agency regarding federal/state/county requirements. Further, the Compliance Officer maintains and disseminates a database of interventions, compliance feedback, updates and standards.

It is the responsibility of the Compliance Officer to review internal audit reports and develop appropriate action at the agency level. This officer establishes and facilitates a statewide Victor Compliance Workgroup to identify priorities, risk areas and appropriate standards and systems.

At hiring, new employees receive training in quality documentation procedures and compliance issues in general, including the False Claims Act. Recertification in these areas is either annually or biannually as required. There is on-going monitoring/auditing of compliance practices as staff receives regular, individual supervision. Regular team meetings and all-staff meetings reinforce sound tenets of compliance and best practices. Upon completion of a new employee's six month on job training and certification, the Compliance Workgroup Members at the site review the employee's evaluation and make recommendations for continued training, supervision, remedial instruction, up to and including continued employment.

Employees who have demonstrated an area of need regarding compliance issues receive supervision and coaching in identified remedial areas. Each situation is evaluated on a case by case basis. Repeated situations or failure to comply with Agency expectations can be cause for disciplinary action as discussed later in this document. *See Attachment C for Personnel Policy—Discipline, page 27.*

The Compliance Workgroup Members conduct regular internal audits and participate in developing standards and systems for individual sites within the Agency. Annually the Compliance Officer assesses

the elements of the code of conduct and evaluates the completeness of compliance standards and procedures. As needed the Compliance Officer communicates pertinent issues to the Executive Administrators and CEO and facilitates consultation as needed to ensure open communication at all times.

The Compliance Officer works closely with the Human Resources department to assure that hiring practices reflect the need for qualified, eligible staff. Prospective employees are subjected to applicable background/state license checks and are expected (if hired) to comply with the Agency standard of ethical conduct. Management, as well, creates an atmosphere of diligence to compliance issues and develops systems and standards that ensure that expectations are clearly stated and enforced. Issues of non-compliance are addressed seriously and in a timely manner. Above all, management sets an example of compliant, professional behavior in the performance of their duties.

As the result of careful planning and attention to compliance issues there are well defined Agency policies regarding expected employee behavior. Copies of these are at each site and implemented by the executive leadership. There are written compliance standards and systems pertaining to documentation quality and action in the event of a suspected non-compliance claim. *See Attachment A for examples of Agency CQI Policies regarding Compliance.*

c. Retention of Records and Information Systems

All client records are stored and maintained in a locked file room in locked metal file cabinets. Charts are checked out according to systems regarding file check out. When charting is completed, the chart is immediately returned to the cabinet or locked storage closet. At the end of the day, the office manager or designee secures the client file cabinets and the file room.

The file room is not accessible to the general public. Charts are monitored by the office administrative staff person. That person and the mental health staff are the only people who have access to the records. During the time the chart is in the mental health staff person's possession, he/she is responsible to see that the chart is not left unattended. It is imperative that all files be returned to the file room following use of the file.

Any unusual request or circumstance regarding client records or confidentiality issues is given to the Executive Director for review. Closed charts are retained and secured for the appropriate amount of time after their final audit. *See Attachment A for Agency CQI Policies regarding chart security, subject Client Records.*

d. Compliance as an Element of Performance Plan

All staff is expected to demonstrate knowledge of compliance procedures pursuant to their role along with the general code of ethical conduct. Employees who do not demonstrate such ability are not to be considered for promotion and are referred for corrective procedures. It is a requirement of any scheduled performance

evaluation that the staff be proficient in appropriate service procedures and compliance issues.

Staff that report compliance violations are not penalized. There is no retribution of any kind. In fact, staff is encouraged to report non-compliance with or without suggestions for alternative action.

2. Designation of a Compliance Officer and Compliance Workgroup

a. Compliance Officer

The Agency Compliance Officer duties include:

- Responsibility for facilitating and maintaining of compliance procedures across all sites in the Agency.
- Investigate and resolve alleged non-compliance issues.
- Develop systems and standards as necessary
- Conduct compliance trainings as needed
- Maintain the compliance reporting mechanism and closely participate in internal audits.

This person has knowledge of Medicaid/MediCal requirements and is separate from the legal department. The Compliance Officer reports directly to the Chief Executive Officer or their designee, can receive confidential communications, and has the ability to conduct internal investigations. *See Attachment B for the Compliance Officer (Quality Assurance Specialist, page 24)*

The Compliance Officer encourages new compliance systems and the development of compliance procedures. This officer demonstrates leadership to enhance the relationship with the Behavioral Health community and participates in agency statewide trainings. In general, the Compliance Officer provides oversight of the compliance system and the Compliance Workgroup.

b. Compliance Workgroup

As part of the agency's continuing dedication to quality services and documentation, there is a Compliance Workgroup. This group is comprised of representatives from the Northern and Southern Regions of the Agency, along with the Compliance Officer. These regional representatives have the responsibility of fully representing all of the program sites within their respective region. Each program site has a designated site representative at the director or supervisor level who communicates with the regional representative and ensures thorough and consistent communication between the individual sites, the Compliance Work Group and the Agency Compliance Officer. The Compliance Officer is the chair of the workgroup.

These core people are charged with monitoring HIPAA and MediCal activities at the program sites. The regional representatives are the first point of interaction with the program sites, as well as the liaisons with the workgroup members and the agency as a whole. They are knowledgeable about their particular region/county's documentation rules/standards and are able to contribute to the Agency's statewide development of quality compliance. Even further, the Compliance

Workgroup representatives work directly with the site representatives to ensure quality assurance specific to the six month documentation certification of newly hired staff at their site.

The Workgroup members meet bi-monthly at minimum, in person or electronically. These meetings expand and refine the Agency's definition of compliance; identify areas of further training; and contribute information for the Compliance Officer's annual report to the Executive Leadership Team and the Board of Directors. As indicated, the Compliance Workgroup establishes or redesigns Agency policy with approval from the Executive Leadership Team.

The Compliance Officer, with feedback from regional Workgroup members, is able to respond in a timely fashion to internal issues. As a workgroup they investigate credible claims of misconduct and make recommendations to the Executive Leadership regarding an appropriate course of action.

In addition the Board of Directors oversees compliance. The board is composed of persons outside the Agency but knowledgeable about behavioral health issues. They routinely monitor the actions of the Compliance Officer/ Workgroup and make recommendations about the implementation of the compliance program.

3. Conducting Effective Training and Education

a. Formal Training Programs

Newly hired staff participates in a New Hire Orientation that acquaints them with Agency protocols and compliance expectations. There is training regarding the Federal False Claims Act and regular recertification thereafter. After each segment of the training, staff sign that they have completed the session. In addition, there is adjunct county and compliance training with respective re-certifications. Further education after this initial training is done by accessing on-site persons and having them sign off on the sessions. Staff is closely monitored for the first 180 days of employment. During this time areas of need are identified and training implemented. Following this initiation period there are annual or bi-annual re-certifications depending on the subject matter. Trainings are also available on-line in an e-training format. Completion of training is closely monitored and records are kept in each personnel file. *See Attachment A for Agency CQI policies regarding Clinical Documentation.*

Special training is provided to supervisors to assist with their identification of compliance issues and focusing on encouraging employees to report non-compliance matters. Proper handling of complaints is emphasized and delineated.

b. Informal On-going Compliance Training

Regular supervision of all staff provides the primary setting for on-going compliance training. Employees are encouraged to discuss current treatment issues and seek resolution early in the process. There is also a random use of the Client Satisfaction Survey to seek feedback from consumers regarding alignment between documented

service delivery and consumer satisfaction. *See Attachment F for the Agency Client Satisfaction Survey, page 39.*

Careful auditing of client charts provides another opportunity to address compliance matters on an on-going basis. Designated staff on site review documentation and make recommendations as needed. Appropriate training is arranged if indicated.

4. Developing Effective Lines of Communication

a. System for Reporting Suspected Non-compliance

Employees who wish to report acts of non-compliance can do so to supervisors, managers, the Compliance Officer, or members of the Compliance Workgroup. If they wish, they can do this in person, by phone (including Agency established toll free number), in written correspondence, or by e-mail. If the reporting party wishes to be anonymous he/she can submit a written correspondence to the Office Service Managers' mail box locally or mail to the Agency corporate post office box. The person can use an on-line reporting form or generate one that would include: date of occurrence, date of report, program, detailed nature of incident, person involved in suspected non-compliance, and the reporter's identity (optional). *See Agency Non Compliance Report form on page 20 and federal reporting information on page 21.*

All reports of actual or suspected non-compliance are given to the Compliance Officer regardless of the manner of the report. Even if another person was the immediate recipient of the report, the

Compliance Officer receives the report as well. At the end of each fiscal year, sooner if necessary, a summary report of all incidents is given to the Board of Directors and CEO.

b. Communication and Access to the Compliance Officer

The Compliance Officer is a known entity in the organization with easy access by employees. The job description is written, published and accessible in the Agency Employee Information Resource Center (EIRC). The specific duties also include answering routine questions regarding compliance and ethical issues. The role of Compliance Officer, as the identified contact and consulting resource is presented to all Directors, to staff at New Hire Orientation and at re-certifications thereafter. Detailed contact information is available to all sites within the Agency.

Timely information notices regarding compliance issues are disseminated by the Compliance Officer typically by e-mail. The Compliance Officer makes regular reports to the Compliance Workgroup regarding trends/areas of need or further training.

5. Auditing and Monitoring

a. Auditing

The Compliance Officer participates in periodic audits of critical operations areas in sites throughout the Agency. These audits focus on general compliance and the specific requirements dictated by individual counties. Reports generated from these audits are shared

with the Compliance Workgroup, Executive Leadership Team and CEO.

These periodic evaluations are performed annually or as appropriate. Based on the results of these audits, sites determine the effectiveness of their compliance programs. Adjustments to trainings and policies and procedures are made accordingly.

b. Monitoring

Any recommendations or corrective actions for sites or employees are monitored until resolution is reached. Focus areas include Code of Conduct and service requirements and regulations. Incidents are shared with the Compliance Workgroup and the Compliance Officer. Violation issues are addressed as needed. Additionally, all employees are encouraged to complete an anonymous online Organizational Climate Survey on an annual basis (*see Attachment D page 30*).

c. Risk Areas

Areas of focus for auditing programs include a number of items.

Some of the most common are:

- Incomplete or missing service documentation
- Missing authorization documentation
- Misrepresentation in documentation
- Inflating number of services

The Compliance Officer has a responsibility to evaluate for the above situations as well as to determine if required deadlines have been met. Special attention is paid to claim rejections or unusual patterns of service. When appropriate auditing forms are developed to assist the audit process.

6. Enforcement Through Publicized Disciplinary Guidelines and Policies
Dealing with Ineligible Persons

a. Consistent Enforcement of Disciplinary Policies

All disciplinary actions are handled on an individual basis. The Personnel Policies manual details the possible range of actions potentially available to enforce Agency policies. Depending on the issue, corrective action could involve additional training, reduced responsibility, reassignment, increased supervision, demotion/transfer, suspension, or termination.

Employees are expected to report actual or suspected cases of non-compliance. There is no retribution or backlash to persons legitimately filing reports of non-compliance.

b. Employment of, and Contracting with, Ineligible Persons

Prospective employees undergo a systematic interview process as the first round of possible employment. If the person is found to be suitable, a background check is performed consisting of Department of Justice fingerprinting clearance, a search of the Health and Human Services Exclusions Program website and the on-line EDEX check of

open/closed Workers Compensation claims. As well there is a review of any professional licenses through the California Board of Behavioral Sciences. The prospect receives a physical exam including TB, drug, and physical abilities tests as a requirement prior to employment. Once employed, health care providers are required to register for a National Provider Identifier (NPI), through the National Plan and Provider Enumeration System. *See Attachment E for Agency policies regarding employee hiring, page 36.*

Employees are required to regularly show proof of a valid driver's license and auto insurance policy. They are required to report any convictions for driving under the influence.

7. Responding to Offenses, Developing Corrective Action Initiatives and Reporting to Government Authorities

a. Responding to Offenses and Developing Corrective Action

The Agency has as a personnel policy to discipline employees who violate Agency rules, are dishonest or disloyal, or who do not perform satisfactorily (*Attachment C*). Although not a requirement, Agency protocol typically involves notifying the employee of the deficiency, arranging for a meeting with the staff and supervisor or, if necessary, meeting with the Executive Director. *See Attachment C for Agency Personnel Policy-Discipline, page 27.*

When an issue of suspected non-compliance is identified, the on-site Compliance Workgroup member and the Compliance Officer are notified. At this point:

- It is determined who shall review the claim and determine the method of investigation.
- A timeline is established for when the incident review will take place.
- The specific elements of the complaint are then evaluated.
- Based on the presence of/severity of the issue, appropriate disciplinary action is taken.
- Finally an action plan is developed to avoid future non-compliance, clarify expectations, and possibly institute additional training.

Records of this and any compliance issues are kept at the site and additionally by the Compliance Officer. Annually these are compiled for a summary of the year's activity.

b. Reporting to the Government

Recent health care reform impose upon Victor an affirmative legal duty to identify and return overpayments obtained through false, inaccurate, or improper claims. Specifically, the Patient Protection and Affordable Care Act of 2010 requires Victor to identify overpayments and self-report within 60 days of identifying an overpayment.

Overpayments retained after the 60 day discovery period are subject to False Claims Act liability. Therefore, Victor diligently identifies, investigates, or reviews suspected overpayments to promptly resolve any questions and to identify the appropriate party to report the overpayment . the local county, California Department of Mental Health, or the Office of Inspector General and Centers for Medicare and Medicaid Services.

Breach notifications of unsecured protected health information are promptly communicated to affected individuals per Health Information Technology for Economic and Clinical Health (HITECH). Victor also provides reporting to the Department of Health and Human Services of privacy breaches that occur, according to the timeframes set forth in the HITECH Act.

Non-Compliance Report Form

Date of report: _____

1. Date of occurrence: _____

2. Program and address: _____

3. Details of incident: _____

4. Person(s) involved in incident: _____

5. Reporting Person's name (optional) _____

Contact phone # (optional) _____

Contact e-mail (optional) _____

Report Fraud



Phone:
1-800-HHS-TIPS
(1-800-447-8477)

E-Mail:
HHSTips@oig.hhs.gov

Fax:
1-800-223-8164

Mail:
Office of Inspector General
Department of Health and Human Services
Attn: HOTLINE
PO Box 23489
Washington, DC 20026

TTY:
1-800-377-4950

 [Download the Contractor Code of Ethics and Business Conduct Poster \(PDF\)](#)
Adobe Acrobat Reader  is required to view PDF files.

Reporting Fraud

All HHS and contractor employees have a responsibility to assist in combating fraud, waste and abuse in all departmental programs. As such you are encouraged to report matters involving fraud, waste and mismanagement in any departmental program(s) to OIG. To assist you, OIG maintains a hotline which offers a confidential means for reporting vital information.

Information is for official use only (For information on confidentiality please contact the hotline and ask about our confidentiality source program).

Each caller is encouraged to assist the OIG by providing information on how they can be contacted for additional information but **caller may remain anonymous**.

To the best of your ability, please provide the following information when contacting the Hotline:

Type of complaint:

Medicare Part-A
Medicare Part-B
Child Support Enforcement
National Institute Of Health
Indian Health Service
Food And Drug Administration
Centers For Disease Control And Prevention
Substance Abuse And Mental Health Services Administration
Health Resources And Services Administration
Aid To Children And Families
All Other HHS Agencies Or Related Programs

HHS department or program being affected by your allegation of fraud waste or abuse/mismanagement:

Administration for Children and Families (ACF)
Child Support Enforcement (CSE)
Centers for Medicare & Medicaid Services (CMS)
Food and Drug Administration (FDA)

National Institutes of Health (NIH)
Office of Disease Control and Prevention (CDC)
Indian Health Service (IHS)
Office of Inspector General (OIG)
Office of the Secretary (OS)
Health Resources and Services Administration (HRSA)
Substance Abuse and Mental Health Administration (SAMSHA)
Administration on Aging (AOA)
Agency for Health Care Policy and Research
Other (please specify)

Please provide the following, if you would like your referral to be submitted anonymously please indicate in your correspondence or phone call:

Your Name
Your Street Address
Your City/County
Your State
Your Zip Code
Your email Address

Subject/Person/Business/Department that allegation is against:

Name of Subject
Title of Subject (if applicable)
Subject's Street Address
Subject's City/County
Subject's State
Subject's Zip Code

Please provide a brief summary relating to your allegation.

Attachment A

- ❖ **Code of Conduct**
- ❖ **Exclusion Screening and Licensure Checks**
- ❖ **Continuous Quality Improvement**
- ❖ **Monthly MediCal Checks**
- ❖ **Mileage Reimbursement**
- ❖ **Medical Records Security**
- ❖ **Release of Information**
- ❖ **Maintenance of the MHS Database**
- ❖ **Case Closure**
- ❖ **Clinical Documentation Due Dates**
- ❖ **Case Opening**
- ❖ **Assessment**
- ❖ **Child and Adolescent Needs and Strengths (CANS)**
- ❖ **Client Plan**

Attachment B

- ❖ **Job Description - Quality Assurance Specialist**

Attachment C

- ❖ **Personnel Policy – Discipline**

Attachment D

- ❖ **Administrative Personnel Procedure – Organizational Climate Survey**

Attachment E

- ❖ **Personnel Form 95 - Code of Conduct**
- ❖ **Personnel Policy – Criminal Record Clearance**
- ❖ **Personnel Policy – Clinical Licensing Standard**

Attachment F

- ❖ **Customer Satisfaction Survey**

Appendix

- ❖ **Administrative Personnel Procedure – Compliance Plan Components**
- ❖ **Administrative Personnel Procedure – Compliance Adherence and Auditing Protocol**
- ❖ **Administrative Personnel Procedure – MediCal Compliance Claim Review Process**